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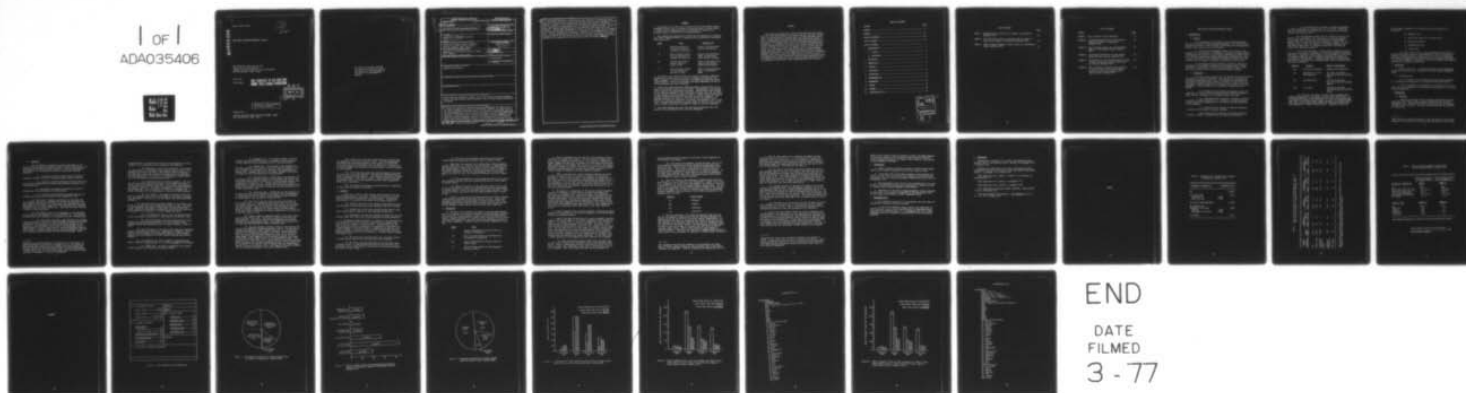
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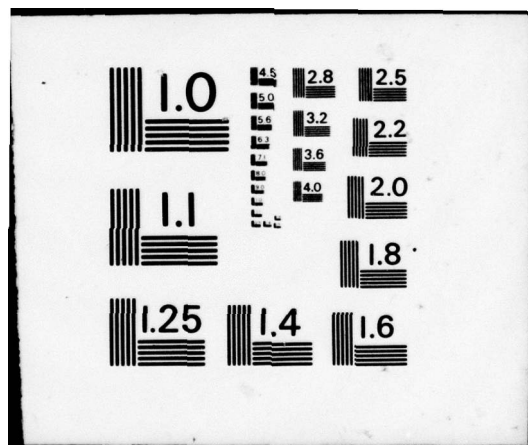
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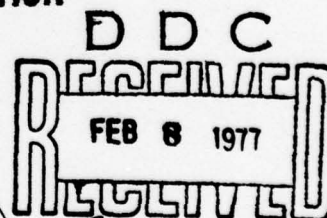
ARMY DENTAL PROGRAM MANAGEMENT INDICES

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April 1976

Final Report

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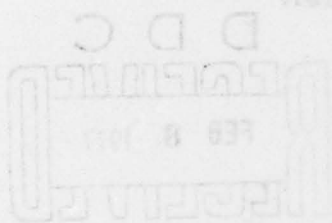
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20. ABSTRACT (Continue on reverse side if necessary and identify by block number) A survey was conducted of patients presenting themselves for dental care at all dental treatment facilities at Fort Rucker, Alabama. At this installation the population authorized dental care consists of active duty personnel and their dependents as well as retired personnel and their dependents. The objective of the study was to provide Army Dental Service Commanders with additional patient management indices for assessing resource utilization. Health Care Studies Division personnel collected data for one month at five dental clinics at Fort Rucker. Approximately 3,700 patient visits comprised		

the study sample data base. Distributions were obtained of the various categories of the population receiving care and the levels of care provided to each category of patient. Four indices were developed and tested to illustrate their usefulness at installation level for managing program resources. Patient visits were equally divided between active duty and other than active duty personnel. The greatest proportion of visits, by level of care, was for primary care, followed by visits for preventive, corrective, and emergency care in that order. Percent distributions of patient visits by level of care and the rate of patient visits per 100 persons by level of care were presented. The indices presented can be employed at the installation level by dental commanders.

SUMMARY

1. The purpose of the study was to develop and test Army dental patient management indices, and to illustrate potential benefit of these indices to Dental Service Commanders/Chiefs of Department of Dentistry for assessing resource utilization for program planning.
2. Four indices were developed and tested and the usefulness to installation Dental Commanders/Chiefs in managing dental programs was illustrated. These indices are:

<u>Index</u>	<u>Date</u>	<u>Indicator of</u>
I	Percent Distribution of Patient Visits by Category of Population	Patient care priorities; resource utilization.
II	Rate of Patient Visits per 100 Population by Category of Population	Patient care priorities; impact on population needs; special programs.
III	Percent Distribution Patient Visits by Level of Care	Level of care priorities; resource utilization; mission effectiveness.
IV	Rate of Patient Visits per 100 Population by Level of Care	Level of care priorities; impact on population needs.

3. The indices were tested by means of a survey of patients presenting themselves for dental care at all dental treatment facilities at Fort Rucker, Alabama. At this installation, the population authorized dental care consisted of active duty personnel and their dependents, as well as retired personnel and their dependents.
4. Health Care Studies Division (HCSD) personnel collected data for one month at five dental clinics at Fort Rucker. Approximately 3,700 patient visits comprised the study sample data base. Distributions were obtained of the various categories of the population receiving care, and the levels of care provided to each category of patient. Patient visits were equally divided between active duty and other than active duty personnel. The greatest proportion of visits by level of care was for primary care, followed by visits for preventive, corrective, and emergency care, in that order. Percent distributions of patient visits by level of care, and the rate of patient visits per 100 persons by level of care were presented.
5. The study findings indicated that the indices described can be employed at the installation level by Dental Commanders.

PREFACE

This study was planned and conducted when priorities for dental care for active duty personnel were based upon age, and when a larger number of installations were authorized to provide dependent dental care. Changes have since occurred which have reduced the number of separate categories of patients for which different priorities had to be applied. In November 1974 revision of the Army Oral Health Maintenance Program eliminated the dental care priority system which was based on the age of an active duty member. About the same time the number of installations which were authorized to provide dependent dental care was reduced. Accordingly, the need for dental program management indices of the type presented in this report has diminished. However, these indices have been demonstrated to be valid, and it is anticipated that at some posts where accurate subgroup populations can be estimated, and where a variety of care is still authorized or may be authorized in the future, these indices may prove to be useful.

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ARMY DENTAL PROGRAM MANAGEMENT INDICES

1. INTRODUCTION.

a. Purpose.

(1) The purpose of this report is to present new indices for use in installation dental program management. Four indices were developed and tested. They are based on the category of the population treated, and on the level of care provided.

(2) Dental program management based on the level of care provided is a new approach. Traditionally, indicators of program effectiveness have been based on the category of dentistry provided. There is an important distinction between categories of dentistry and levels of care. Each level of care crosses all categories of dentistry and, conversely, each category of dentistry crosses all levels of care.

(3) This report does not, however, attempt to compare the usefulness of the approach presented to any other approach. Rather, the report is descriptive in nature and is intended to offer a distinctively different view of an installation's dental program.

b. Background.

(1) Five levels of dental care are defined by Army Regulation.¹ The definitions serve as guidelines only, and are for the purpose of informally categorizing dental care. No provision is presently made for formally collecting data pertaining to levels of care, either for reporting to higher headquarters or for local use to assist in program management. The five levels of care defined by regulation are as follow:

(a) Emergency Care--consists of measures provided for conditions of trauma or disease requiring prompt attention because of their severity, acuteness, or the degree of pain they cause.

(b) Interceptive Care--consists of measures undertaken to control existing disease lesions. Restoration of function and/or esthetics may occur incidentally to, but are not specific objectives of the treatment.

(c) Preventive Care--consists of measures undertaken to prevent the occurrence of disease processes.

(d) Corrective Care--consists of measures undertaken to attain or restore an optimum state of function and esthetics.

(e) Definitive Care--consists of measures undertaken to attain and maintain an optimum state of oral health. Definitive care may consist only of preventive care or it may include both preventive and corrective care.

(2) The ordering by which the five levels of care are presented is not identified in the regulation as a priority ordering. The ordering does, together with the wording of the definitions, suggest that a system of priorities is intended. Indeed, the ordering would seem to correlate highly with the stated mission of the Army Medical Department, "to maintain the health of the Army and conserve its fighting strength."²

(3) On the other hand, a strict priority system for providing care to the various categories of a military community's population does exist. Depending on the category of the population, its priority for being provided care may be further qualified by its degree of entitlement to receive care. In general, the official long standing priorities and guidelines for providing health care--to include dental care--are as follows:³

<u>Priority</u>	<u>Category</u>	<u>Degree of Entitlement</u>
1st	Active Duty Personnel	Complete and unqualified.
2nd	Dependents of Active Duty Personnel	Care must be provided when facilities and staffing permit.
3rd	Retired/Retired	Care may be provided when facilities and staffing permit.
4th	All others	Care may be provided when facilities and staffing permit.

(4) The above priorities are even further qualified when considering dependents' entitlement to dental care, specifically. The further qualification is that dependents of active duty personnel may (not "must") be provided routine dental care only at overseas installations and at those installations within the United States which have been designated as "remote" installations.⁴ Otherwise, within the

United States, dependents are authorized only the following five services:^{5*}

- 1) Emergency care.
- 2) Dental care adjunctive to medical care.
- 3) Preventive measures.
- 4) Examination/X-rays.
- 5) Consultation.

(5) How, then, can one go about examining how effectively an installation dental program is being managed in view of the carefully ordered and defined levels of dental care, and in view of established priorities and guidelines for providing care to the various categories of a military community's population? This was the single major research question to be answered by this study.

2. OBJECTIVES.

a. Overall objective. To develop Army dental program management indices and illustrate their usefulness for dental service commanders/chiefs.

b. Sub-objectives.

(1) To determine the distribution of the various categories of a population receiving care at a selected US Army installation.

(2) To determine the distribution of the levels of care provided the various categories of a population receiving care at a selected US Army installation.

3. METHODOLOGY.

a. Overview.

Health Care Studies Division personnel surveyed all patients reporting to Fort Rucker dental treatment facilities and collected demographic data. Following treatment, records were used to determine the type of care provided. The data collected served as the data base for this study.

*This creates an interesting paradox in that dependents of active duty personnel have priority for receiving these five services over retired

b. Procedure.

(1) In addition to meeting the stated objectives of the study, the methodology was designed so that it may be duplicated at the installation level with available resources. To help insure general applicability, the methodology was based on having the following available:

(a) A study site with the widest range of population categories entitled to receive the widest range of dental services.

(b) A means of reliably estimating the base populations of the various categories and selected sub-categories entitled to receive dental care.

(c) Meaningful and generally acceptable criteria for categorizing the various levels of care provided.

(d) A means of collecting and processing data and information which could be duplicated at the installation level.

(2) Fort Rucker, Alabama, was selected as the study site. As a "remote" installation, dependents of active duty personnel were authorized routine dental care to the degree that staffing and facilities permitted. All major categories of the population were therefore entitled to receive routine dental care. The study site also afforded a sizable retired population.

(3) The combined total of all categories of the population at the study site was estimated to be 23,826 (Table 1). The estimate was derived for each category of the population by the following means:

(a) Active Duty Personnel. The installation's Standard Installation/Division Personnel System (SIDPERS) Interface Branch Office provided the actual number of active duty personnel assigned at the study site. The information was provided in two groupings, by age: those personnel 25 years of age and over, and those personnel under 25 years of age. A special program then in existence mandated the providing of differing dental services for each of the groupings. Their

personnel; yet retired personnel are entitled to routine dental care whereas dependents of active duty personnel are not. The paradox is more reality than fantasy when one considers that those preparatory services required by retired personnel prior to their being provided "routine dental care" are those same services which must first be made available to dependents of active duty personnel.

inclusion serves to illustrate how selected sub-categories of a major category of the population can be included in this approach.

(b) Dependents of Active Duty Personnel. The estimate for this category of the population was derived from a ratio of 1.73 dependents per active duty male. (The number of female personnel at the study site, less than a Company, was considered to be negligible for this computation). The ratio of 1.73 was the most current available from the Army's Military Personnel Center.⁶

(c) Retired Personnel and their Dependents. The total used for the retired population is equal to that number estimated to use the study site's medical facilities. The estimate was provided by the hospital registrar. The number of dependents of retired personnel was derived from a ratio provided by the Office of Management and Budget, Washington, DC (2.2 dependents of retired per retired member).⁷

(d) "All Others." The number of persons in this category was estimated from a ratio also provided by the Office of Management and Budget.⁷ The ratio is one "all others" per three active duty personnel.

(4) All of the dental services rendered to the various categories of the population were categorized by level of care. The level of care categories were based on those defined by Army Regulation,¹ namely: emergency, interceptive, preventive, corrective, and definitive. For purposes of this approach, two basic changes were made:

(a) The "definitive" level of care was omitted because it was very similar in definition to that given for "corrective" care.

(b) The term "primary care" was substituted for "interceptive care"--a personal preference of the study project officer. "Primary" seemed more appropriate since it means, literally, "first in order."

(5) The four levels of care used in this study were emergency, primary, preventive, and corrective. Examinations, though not truly a level of care as defined in the regulation, made up a fifth category. Together, the five categories allow for properly placing every service rendered.

(6) To standardize the task of properly categorizing each service rendered by level of care, the following criteria were developed.

(a) Examination. Any type of examination was recorded in this category if it was the only service provided.

(b) Emergency Care. If a patient stated to the data recorder that he was seeking care for a painful condition, the data recorder indicated that an emergency level of care was provided.

(c) Primary Care. Entries made on the patient's SF 603 which indicated the presence of an active diseased condition, and that treatment was provided for the condition, were categorized as primary care. Standard Form 603 is the dental treatment record which is prepared by the attending dentist on each patient.

(d) Preventive Care. Entries made on the patient's SF 603 stating that a complete prophylaxis was provided, and without any terminology identifying the presence of a related disease process, were categorized as preventive care. Entries indicating that a partial prophylaxis or scaling only was provided were recorded as primary care. Patient visits where counseling in self-care only was provided were recorded as preventive care.

(e) Corrective Care. Entries made on the patient's SF 603 which indicated that treatment was provided, other than emergency or preventive, but did not have an active disease process identified as being present, were recorded as corrective care.

(7) Only one of the four levels of care was recorded for each patient visit. An examination was recorded only if it was the only service provided. In a few instances both primary and corrective care were provided. When this did occur, only the primary level of care was recorded. Otherwise, all entries taken from the patient's SF 603 were readily interpreted as being an examination or as being one of the four levels of care.

(8) Figure 1 shows a simplified version of the data collection form used in the study. The form was used at each of the five dental clinics. Each of the clinics had a designated data recorder stationed at the receptionist's desk. Study data were collected over a 16 duty day period during the month of February 1974.

(9) The data recorder initiated a form for each patient presenting for treatment by completing Sections I and II. In the case of a patient stating that he had a painful condition, he also completed Section III by checking the emergency care block. After initiating a form, the patient was processed through the clinic in the clinic's normal manner. Upon completion of the services rendered, the patient returned his official dental folder to the receptionist's desk. The data recorder at this time, or at a later time if it was more convenient, copies the entry from the Services Rendered section of the patient's SF 603 (contained in the patient's dental folder) onto the corresponding section of the data collection form. This completed the data recorder's role in recording information on the data collection form.

(10) Section III of the data collection form, Level of Care, was completed by the study's project officer. This was accomplished by applying the criteria developed for this purpose to each SF 603 entry and checking the appropriate block in Section III. Having only one person complete this section of the form helped to further standardize the approach.

(11) All of the data collection forms initiated at the study site were used in the data analysis. The data were keypunched and processed utilizing CDC 6500 computer. (The computer was used only because of its convenience to the project officer. After having the data keypunched into cards, all of the analysis could have been accomplished using only a card-sorter).

(12) The entire methodology was pretested prior to beginning the data collection phase of the study.

4. FINDINGS.

a. There was a total of 3,648 patient visits during 16 duty day data collection phase of the study. Included in the total are 1,078 visits during which an examination only was provided. A percentage distribution of all patient visits shows the following (Figure 2):

(1) Patient visits were about equally divided between active duty personnel and other than active duty personnel (49.1% vs 50.9%).

(2) Patient visits were about equally divided between those active duty personnel under age 25 and those aged 25 and over.

(3) Dependents of active duty personnel recorded over two and one-half times more visits than retired personnel and their dependents.

b. The dental benefits derived by a category of the population are best indicated by the rate of patient visits by that category rather than by the total number of patient visits. Viewed another way, the rate of patient visits by a population are indicative of the impact of a dental program on the dental needs of a population studied are illustrated by Figure 3. They can be seen to differ dramatically from the simple percentage distribution from Figure 2. The most notable findings from Figure 3 are:

(1) The active duty population had a rate of patient visits 2.6 times greater than that for the non-active duty population.

(2) The active duty population aged 25 and over had a rate of patient visits 4.1 times greater than that for the non-active duty population; and 2.2 times greater than that for the active duty population under 25 years of age.

(3) The active duty dependent population and the retired/retired dependent population had similar rates of patient visits.

c. There were 2,570 patient visits during which either emergency, primary, preventive, or corrective care was provided. A simple percentage distribution of these visits by level of care is shown in Figure 4. The largest number of visits was recorded for primary care, followed by visits for preventive, corrective, and emergency care in that order. Within each level of care, the following distribution was noted (Figure 5):

(1) With the exception of the preventive level of care, active duty personnel and non-active duty personnel had about an equal number of patient visits.

(2) With the exception of the corrective level of care, each of the age groupings of active duty personnel had about an equal number of patient visits. Active duty personnel aged 25 and over had 2.5 times as many corrective care visits than did those personnel under 25 years of age.

d. Figure 6 illustrates the difference between the rates of patient visits and the percentage distribution by level of care. Active duty personnel, particularly those personnel 25 years of age and over, had proportionately far more patient visits by every level of care (excluding the emergency level) than did the non-active duty categories.

5. DISCUSSION.

a. The above data illustrates an aspect of dental program management as it relates to the various categories of the population supported or to the level of care provided, or both. The data are presented as either a percent distribution of patient visits or as the rate of patient visits per 100 population. Each set of data can therefore be placed in one of four categories. Viewed as indices, the four categories of data are:

<u>Index</u>	<u>Data</u>
I	Percent Distribution of Patient Visits by Category of Population
II	Rate of Patient Visits per 100 Population by Category of Population
III	Percent Distribution of Patient Visits by Level of Care
IV	Rate of Patient Visits per 100 Population by Level of Care

b. Table 3 illustrates how the data may be structured to serve as indicators of program effectiveness. The data shown are summary data taken from the findings presented above. For purposes of program evaluation, summary data meet the requirements for indicating effectiveness. (When inspection of the summary data for any one or more of the indices indicates a significant variance from what one expects from his program, selected cross-tabulations of the base data already collected can, of course, provide for additional and more detailed insight).

c. Index I indicates how a dental program's resources are being utilized to provide care for the various categories of the patient population. From the data in Table 3, for example, the indication is that about one-half of the program's resources were providing for active duty personnel. Care was about equally divided between those active duty personnel 25 years of age and over and those under 25 years of age. The other one-half of the program's resources were providing for the non-active duty population.

d. The degree of acceptability of this use of a dental program's resources is dependent in large measure on established population priorities for providing care. Again from Index I, the indication is that the care provided at the study site is indeed consistent with established priorities. That is, the active duty category had the most patient visits (46.1%), followed by dependents of active duty (39.2%), retired and their dependents (13.3%), and finally, "all others" (1.4%). Since active duty personnel have equal priority for care, regardless of age, there is consistency within that group by this index (24.0% vs 22.1%).

e. Index I indicates that the dental program's resources are being utilized to provide care for the various categories of the patient population in an acceptable manner.

f. Index II provides an indication of a dental program's relative impact on the dental needs of the various categories of the patient population. At the same time, it provides an additional view of program effectiveness in meeting patient care priorities. The latter is in terms of proportionate benefits received by each category of the population. The data from Table 3 for this index, for example, indicate that active duty personnel are receiving proportionately far more benefits from the program's resources than are the non-active duty population. Since active duty personnel are in the highest priority category, this finding could be interpreted as highly acceptable. On the other hand, a closer inspection of the summary data also indicates the following:

(1) Those active duty personnel aged 25 and over had twice as many of their dental needs attended to as did those personnel under age 25. Based on established priorities entitling all active duty personnel to equal care, regardless of age, such a distribution of care is not acceptable. There is an indication that the two groupings are

receiving disproportionate amounts of care and a closer inspection of the situation is indicated.

(2) The active duty dependent, retired military, and the retired dependent populations are being provided proportionately equal amounts of care. This is based on the similarity between their rates of patient visits. This could be interpreted as being inconsistent with the priority ordering for providing care for these two groups. On the other hand, assuming that larger number of active duty dependents are being treated at the study site, the proportionately equal amounts of care might be judged as being acceptable.

g. Index III indicates the direction of emphasis being placed on those levels of care as defined by Army Regulation.¹ Based on the direction, judgements can be made about the program's utilization of resources by level of care and about the program's mission effectiveness. For purposes of this approach, mission effectiveness is assumed if the distribution of the summary data in Table 3 correlates well with the following priority ordering of the four levels of care (with the exception of the emergency level of care):

<u>Priority</u>	<u>Level of Care</u>
1st	Emergency
2nd	Primary
3rd	Preventive
4th	Corrective

h. The data from Table 3 for Index III indicates that over one-half of the program's resources were used for providing emergency and primary care (6.1% and 48.1% of all patient visits, respectively). Almost one-third were used for preventive care (30.0% of patient visits). The remainder of the program's resources were used for providing corrective care (15.8% of patient visits). The distribution of patient visits by level of care can be seen to correlate very well with the priority ordering present above. Mission effectiveness of this program is therefore assumed. Similarly, the direction of emphasis being placed on those levels of care as defined by regulation is judged highly acceptable.*

*The judgements made here and elsewhere in the discussion are being made, of course, without having any other baseline data of this nature available for comparison. They are therefore quite subjective and it is

i. Index IV, with summary data, indicates the impact on total population needs by level of care. It is therefore only useful for comparison with total populations from other programs. With specific data from each category of the population, however, Index IV indicates the relative impact on population needs by level of care and by category of the population. (See Figure 6 and Table 2).

(1) The rate of corrective care patient visits for active duty personnel aged 25 and over, for example, indicates that this category of the population is having their corrective care needs met at a rate six times that of any other category--including active duty personnel under age 25. As already pointed out, a special program then in effect likely accounted for a large part of this difference. Also, the active duty population over 25 years of age may have a higher requirement for corrective care than those under age 25.

(2) Another statistic of interest from Figure 6 is the distribution of preventive care. The distribution indicates that active duty personnel under age 25 are being provided preventive care at a rate which is less than one-half the rate for personnel aged 25 and over. In fact, their rate of preventive care patient visits is just slightly above the rate for the non-active duty population. (A similar distribution can be seen between active duty under age 25 and non-active duty for corrective care).

(3) From Table 2 it can be seen that the two major non-active duty categories of the population are being provided care at similar rates by each level of care. This is not strictly consistent with established priorities for these two groupings of the population.

j. Each of the three examples given for Index IV indicates that, proportionately, the distribution of care among selected categories of the population is not consistent with the priorities for providing care. As with all of the indices presented, such an indication does not mean that there is an inconsistency. It does mean that to accurately evaluate specific areas of the program might require additional insight. Such insight can be had from selected cross-tabulations of this type of data; from the data and information already collected on an ongoing

recognized that they do not necessarily represent the opinions of others. In any event, they do serve to illustrate the concept. After having established baseline data from a given installation program or from other programs, subsequent periodic evaluations would allow for more objective judgements.

basis; from a review of special programs in effect--including programs affecting the mission of the population being supported; from age-related disease differences; or, simply, from a review of local dental program management procedures.

6. CONCLUSIONS.

a. Dental treatment procedures recorded on SF 603 during patient visits can be readily classified as one of four levels of care.

b. If the base size of each major category of the population entitled to dental care, and selected sub-categories of the active duty population, could be accurately estimated, these indices can be used as a management tool.

c. Data pertaining to the levels of care provided and to the categories of the population treated can be structured as indices and used to indicate dental program management effectiveness.

d. Application of the dental program management indices presented in this report can be readily accomplished at the installation level with the resources available to dental commanders/chiefs.

7. RECOMMENDATIONS.

a. For information purposes it is recommended that this report be distributed to dental activities worldwide.

b. In view of the different types of dental care authorized at different posts, and in view of the difficulty in identifying populations served at different posts, it is recommended that use of these management indices be optional at the discretion of the local dental authority.

8. REFERENCES.

¹Headquarters, Department of the Army, Army Regulation 40-3, "Medical, Dental, and Veterinary Care," Chapter 10, paragraph 10-1, 17 September 1973.

²Headquarters, Department of the Army, Army Regulation 40-1, "Composition, Mission, and Function of the Army Medical Department," Chapter 1, paragraph 1-4, 24 August 1970.

³Army Regulation 40-3, Chapter 2, Figure 2-1 and Chapter 10, paragraph 10-2, 3a.

⁴Army Regulation 40-3, Chapter 4, paragraph 4-18.

⁵Army Regulation 40-3, Chapter 4, paragraph 4-16j.

⁶U.S. Army Military Personnel Center, DAPC-PMP. Report Number 12-73-E, 30 November 1972.

⁷"OMB Seeks Change with Continuity, "U.S. Medicine. Vol 10, No. 2, p. 27, 15 January 1974.

Table 1. Estimated total population by category of population, February 1974.

CATEGORY OF POPULATION		ESTIMATED TOTAL
All		23,826
All Active Duty		6,524
Under age 25	4,396	
Age 25 or over	2,128	
All Active Duty Dependents		11,287
All Retired and Dependents of Retired		3,840
Retired	1,200	
Dependents of retired	2,640	
All Others		2,175

Table 2. Rate of patient visits per 100 population by level of care and by category of population, February 1974

CATEGORY OF POPULATION	TOTAL NUMBER	EMERGENCY		PRIMARY		PREVENTIVE		CORRECTIVE	
		Number	Rate Per 100*	Number	Rate Per 100	Number	Rate Per 100	Number	Rate Per 100
All	2,571	156	.7	1,239	5.2	770	3.2	406	1.7
Active Duty	1,185	52	.8	609	9.3	308	4.7	216	3.3
Dependents of Active Duty	1,007	80	.7	442	3.9	355	3.1	131	1.2
Retired/Dependents	342	23	.6	162	4.2	99	2.8	58	1.5
All Others	36	1	--	26	1.2	8	.4	1	--

*Rate per 100 was calculated by dividing the actual patient workload by level of care into the respective category of population projections in Table 1.

Table 3. Dental program management indices based on 2,570 patient visits, February 1974.

	Percent Distribution of Patient Visits	Rate of Patient Visits per 100 Population
<u>Category of Population</u>	<u>INDEX I</u>	<u>INDEX II</u>
All	100.0	10.8
Active duty age 25 or over	24.0	28.9
Active duty under age 25	22.1	13.0
Active duty dependent	39.2	8.9
Retired/retired dependent	13.3	9.1
All others	1.4	1.6

*Percentage distribution of patient visits were derived as follows:

$$\frac{\text{Actual patient visits for each category}}{\text{Total patient workload}} \times 100$$

INVESTIGATION TYPE	
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95. <input type="checkbox"/> ...	96. <input type="checkbox"/> ...
97. <input type="checkbox"/> ...	98. <input type="checkbox"/> ...
99. <input type="checkbox"/> ...	100. <input type="checkbox"/> ...

FIGURES

I. IDENTIFICATION CODES		PATIENT
Day of Month.....	<input type="checkbox"/> <input type="checkbox"/>	DOCTOR
Clinic Number.....	<input type="checkbox"/>	III. LEVEL OF CARE
Patient Number.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<u>Examination</u> <input type="checkbox"/>
II. CATEGORY OF PATIENT		<u>Emergency Care</u> <input type="checkbox"/>
<u>Active Duty:</u>		<u>Primary Care</u> <input type="checkbox"/>
Under age 25..... <input type="checkbox"/>		<u>Preventive Care</u> <input type="checkbox"/>
Age 25 or over..... <input type="checkbox"/>		<u>Corrective Care</u> <input type="checkbox"/>
<u>Dependent of Active Duty</u> .. <input type="checkbox"/>		REMARKS:
<u>Retired/Dependent</u> <input type="checkbox"/>		
<u>All Others</u> <input type="checkbox"/>		
SF 603 Entry (Services Rendered):		

Figure 1. Data collection form--simplified.

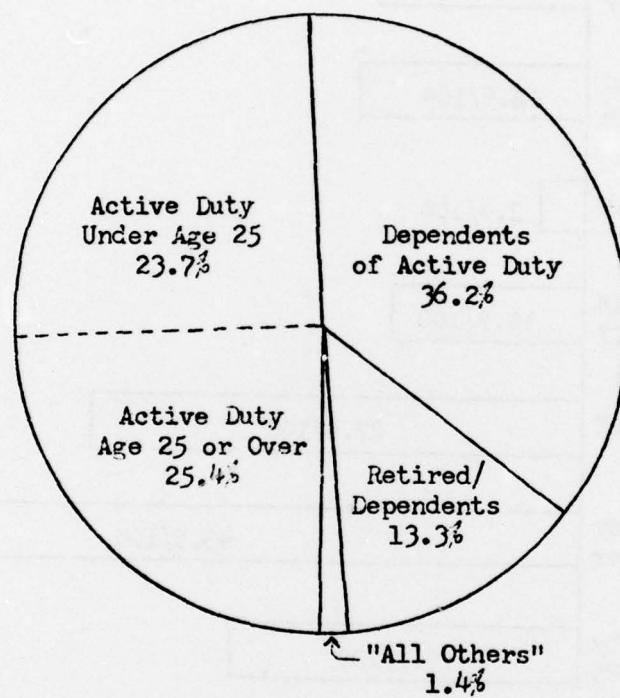


Figure 2. Percentage distribution of 3,648 patient visits by category of population, February 1974.

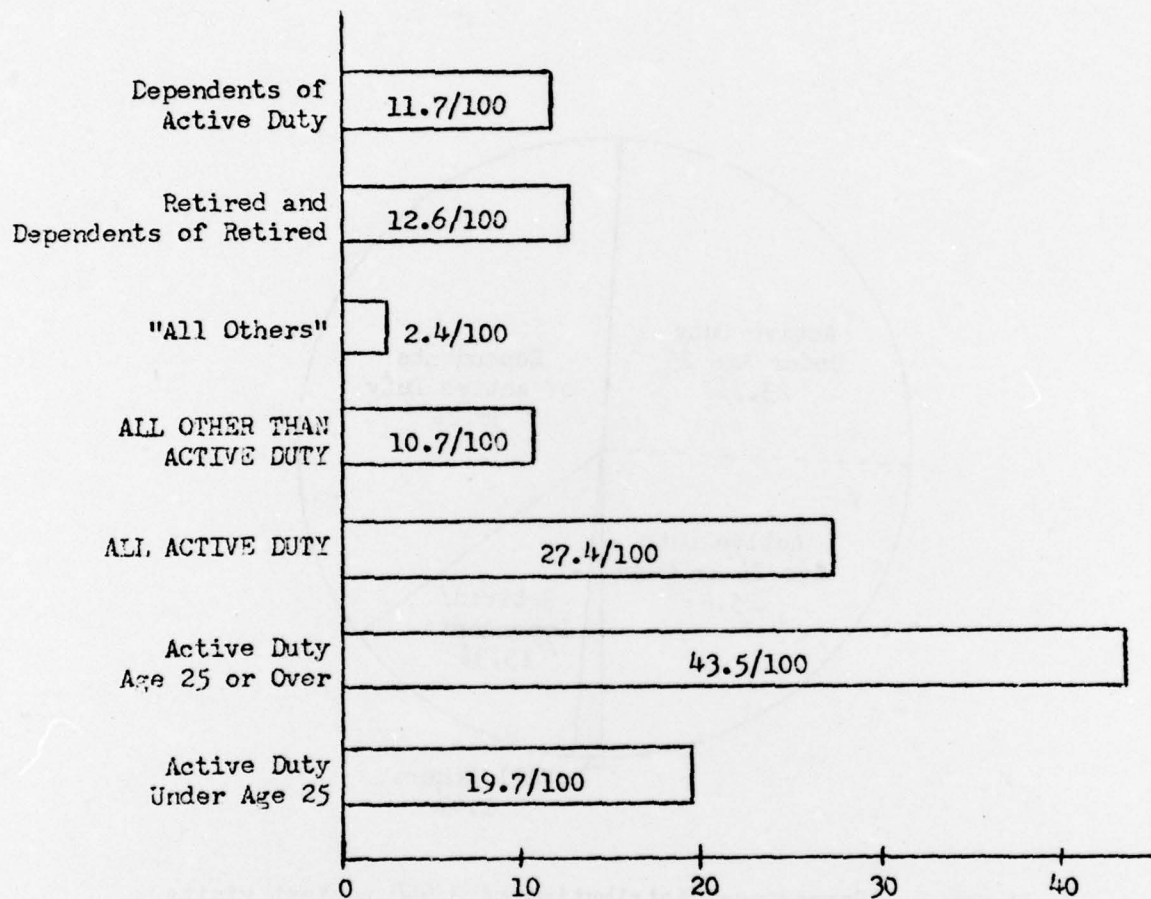


Figure 3. Rate of patient visits per 100 population per month by category of population, based on 3,648 patient visits, February 1974

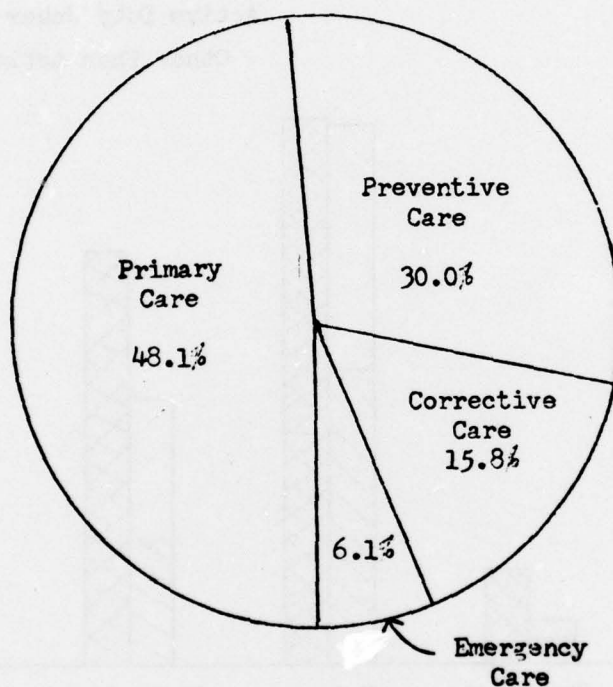


Figure 4. Percentage distribution of 2,570 patient visits by level of care, February 1974.

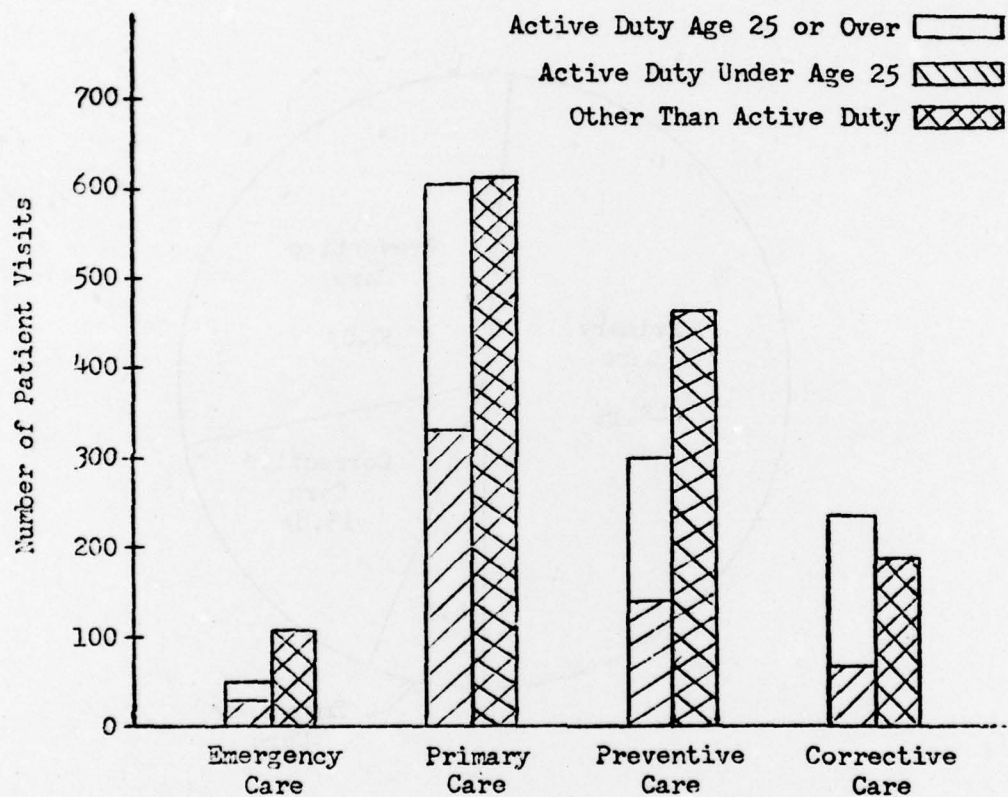


Figure 5. Distribution of 2,570 patient visits by level of care, active duty by age vs. other than active duty, February 1974.

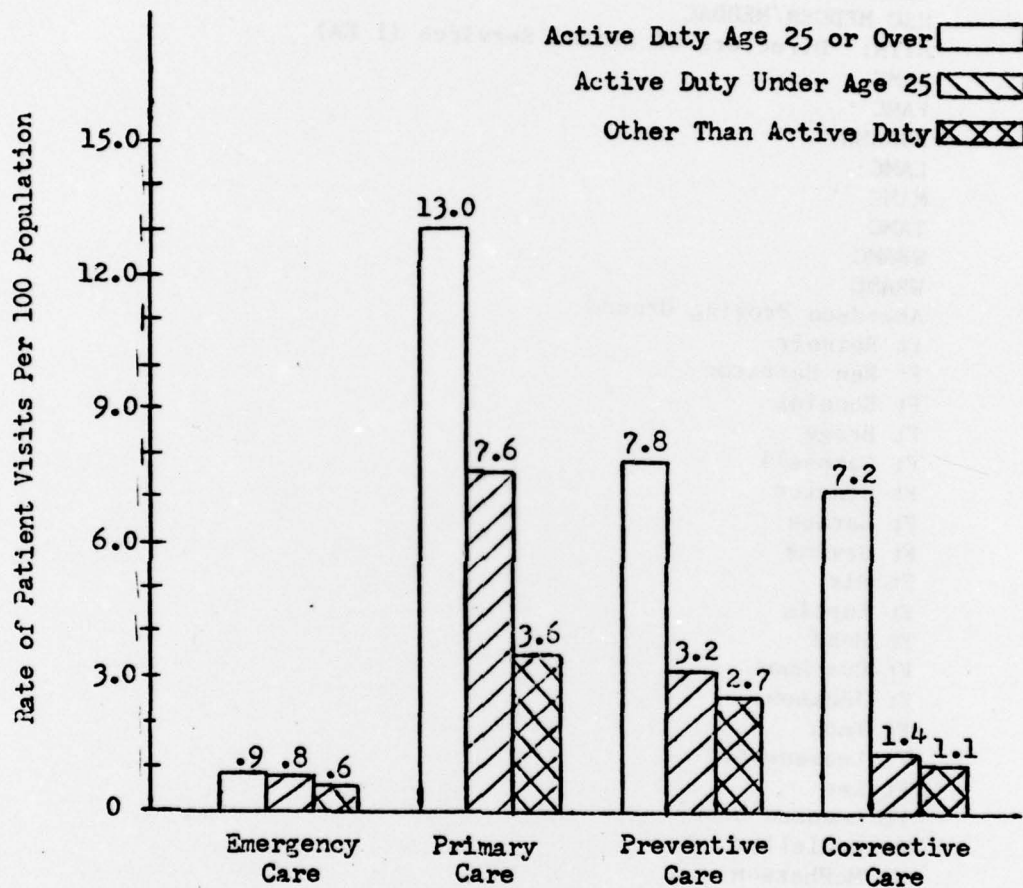


Figure 6. Rate of patient visits per 100 population by level of care, active duty by age vs. other than active duty, based on 2,570 patient visits, February 1974.

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Ft Stewart

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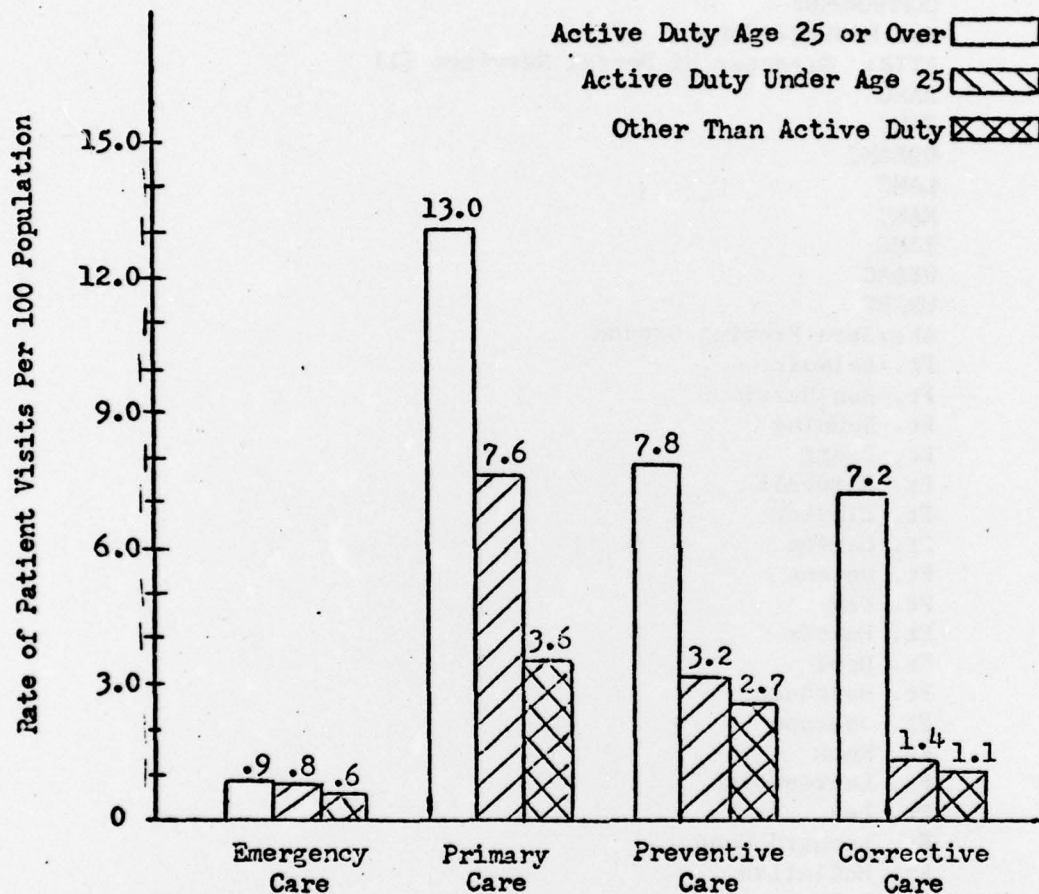


Figure 6. Rate of patient visits per 100 population by level of care, active duty by age vs. other than active duty, based on 2,570 patient visits, February 1974.

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